Mississippi Trauma Care Trust Fund

Reimbursement for Uncompensated Care Process Manual

Mississippi State Department of Health
Office of Emergency Planning and Response
Post Office Box 1700
Jackson, Mississippi 39215-1700

January 2005
Applies to Trauma Care Delivered
January 1 – December 31, 2004

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HISTORY OF THE MISSISSIPPI TRAUMA CARE TRUST FUND

The Mississippi Trauma Care Trust Fund ("the Fund") was created by the Mississippi Legislature to assist in the development of an inclusive statewide trauma system. Administered by the Mississippi State Department of Health (MSDH), Bureau of Emergency Medical Services (BEMS), the Fund is a special $6 million fund derived from the tobacco expendable fund and from assessments on fines paid by moving traffic violators. The purpose of the Fund is restricted to trauma systems development in three areas: regional trauma system administration, hospital/physician uncompensated trauma care services and state trauma system management. (This procedure manual will focus on reimbursement of uncompensated care delivered by eligible providers.) All funds have been distributed annually since the first claim year, January – December 1999.

The Mississippi Trauma Advisory Committee (MTAC) acts as the advisory body for the trauma care system development and provides technical support to the MSDH in all areas of trauma care system design, trauma standards, data collection and evaluation, continuous quality improvement, trauma care system funding and evaluation of the trauma care system and trauma care programs.

The MTAC membership consist of: one licensed physician who is appointed from a list of nominees presented by the Mississippi Trauma Committee, American College of Surgeons; one licensed physician who is appointed from a list of nominees who are actively engaged in rendering emergency medical services presented by the Mississippi State Medical Association; one registered nurse whose employer renders emergency medical service which is appointed from a list of nominees presented by the Mississippi Nurse Association; two hospital administrators who are employees of hospitals that provide emergency medical services, which are appointed from a list of nominees presented by the Mississippi Hospital Association; one licensed physician who is appointed from a list of nominees presented by the Mississippi Chapter of the American College of Emergency Physicians; one representative from each designated Trauma Care Region who is appointed from a list of nominees submitted by each Trauma Region; one EMT-Paramedic whose employer renders emergency medical services in a designated Trauma Care Region; one representative from the Mississippi Department of Rehabilitation Services; one member who is a person who has been a recipient of trauma care in Mississippi or who has an immediate family member who has been a recipient of trauma care in Mississippi; and one licensed neurosurgeon who is appointed from a list of nominees presented by the Mississippi State Medical Association.

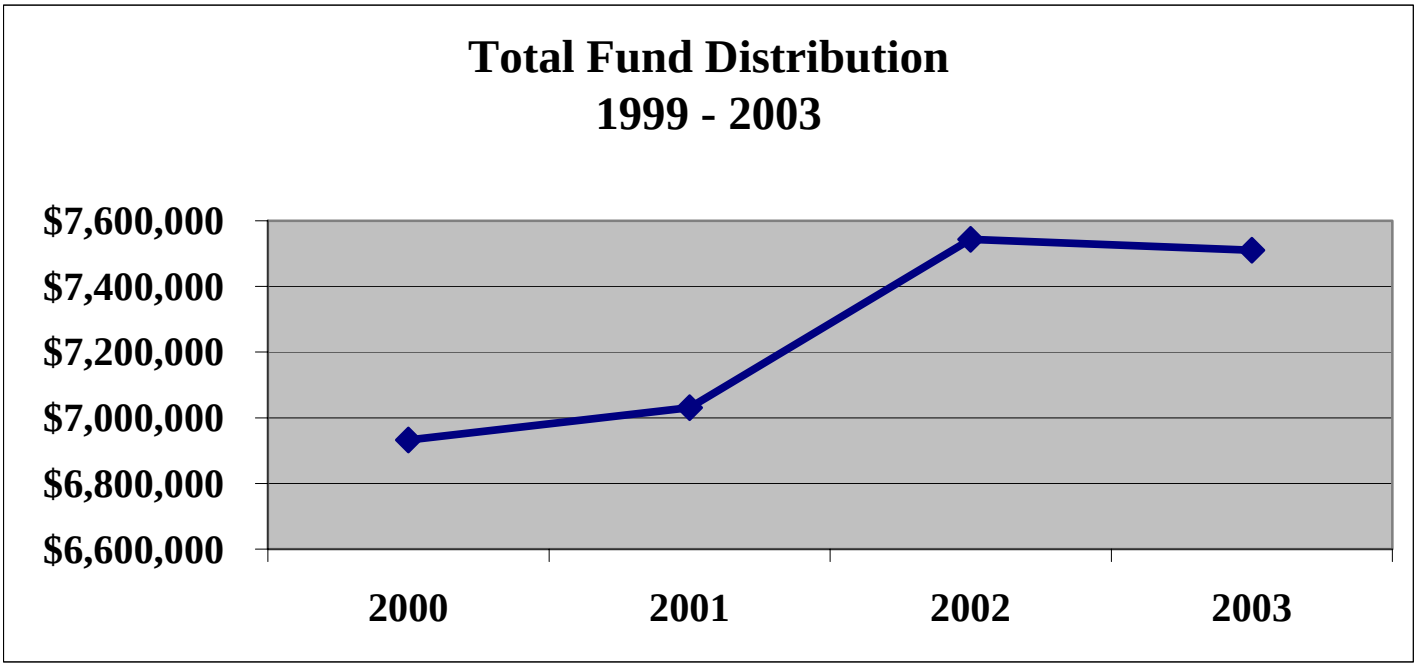
This document provides detailed information about access to the Fund by designated trauma care regions in Mississippi. Only hospitals that have been designated as trauma centers by BEMS are eligible to apply for reimbursement from the Fund. Only qualified physicians in certain specialties are eligible to apply for reimbursement from the Fund. No individual hospital or physician may directly apply for these funds. Non-designated hospitals within designated trauma regions are not eligible for these funds, nor are physicians in qualified specialties that deliver trauma care at non-designated hospitals.

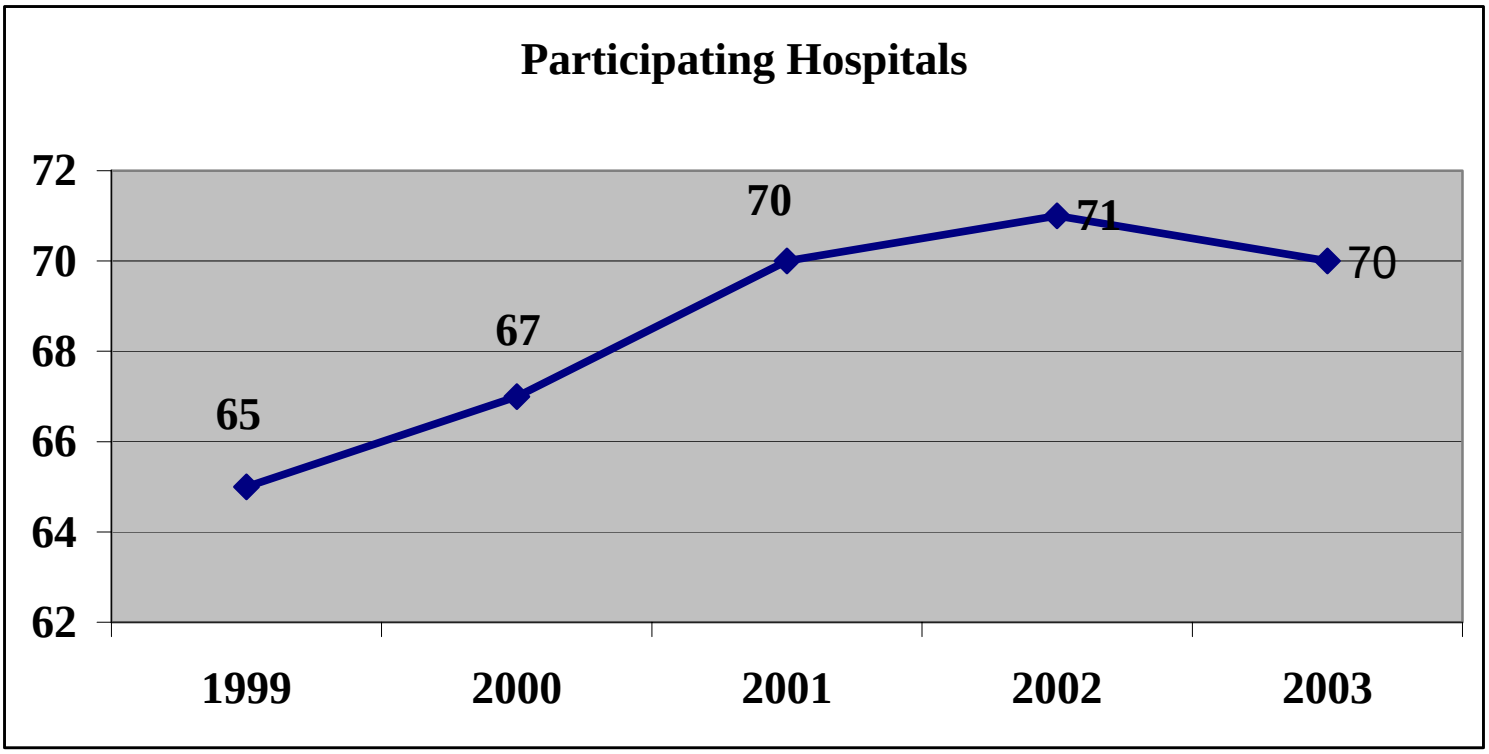
FUND DISTRIBUTION FOR UNCOMPENSATED CARE
1999 – 2003

	2003	2002	2001	2000	1999
Total Fund	**$ 7,510,172.00**	**$ 7,543,809.00**	**$ 7,030,484.00**	**$ 6,931,988.00**	**$ 6,538,545.00**
Total Hospital Fund	5,257,120.40	5,280,666.30	4,921,338.80	4,852,391.60	4,576,981.50
Total Surgeon Fund	1,871,614.10	1,823,415.40	1,829,106.66	2,079,596.40	1,961,563.50
*Total Anesthesiologist Fund	381,427.50	439,727.30	280,038.54	N/A	N/A

Participating Hospitals	70	70	70	67	65
Participating Physicians	362	363	314	216	157

*Anesthesiologists did not become eligible to participate in the Fund until claim year January – December 2001.




Participating Hospitals
72
70
68
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64
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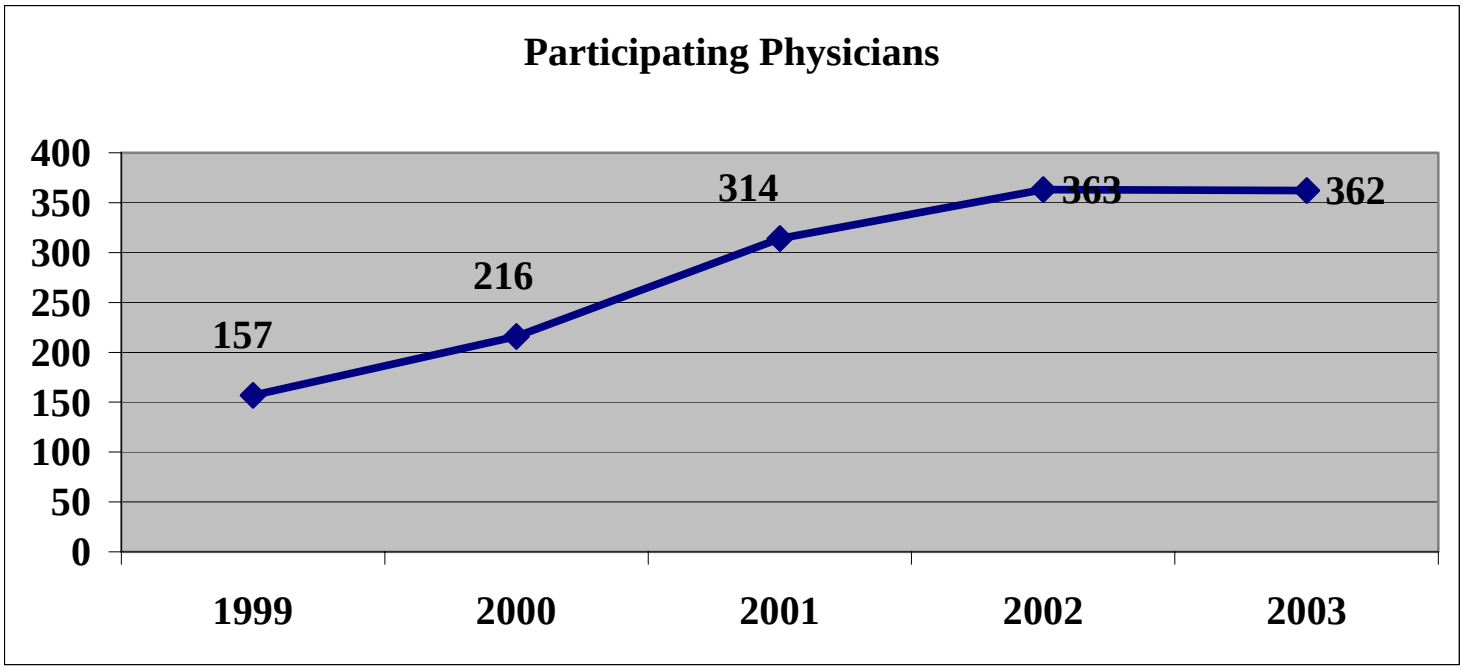
71
70
1999
2000
2001
2002
2003


Participating Physicians
400
350
300
250
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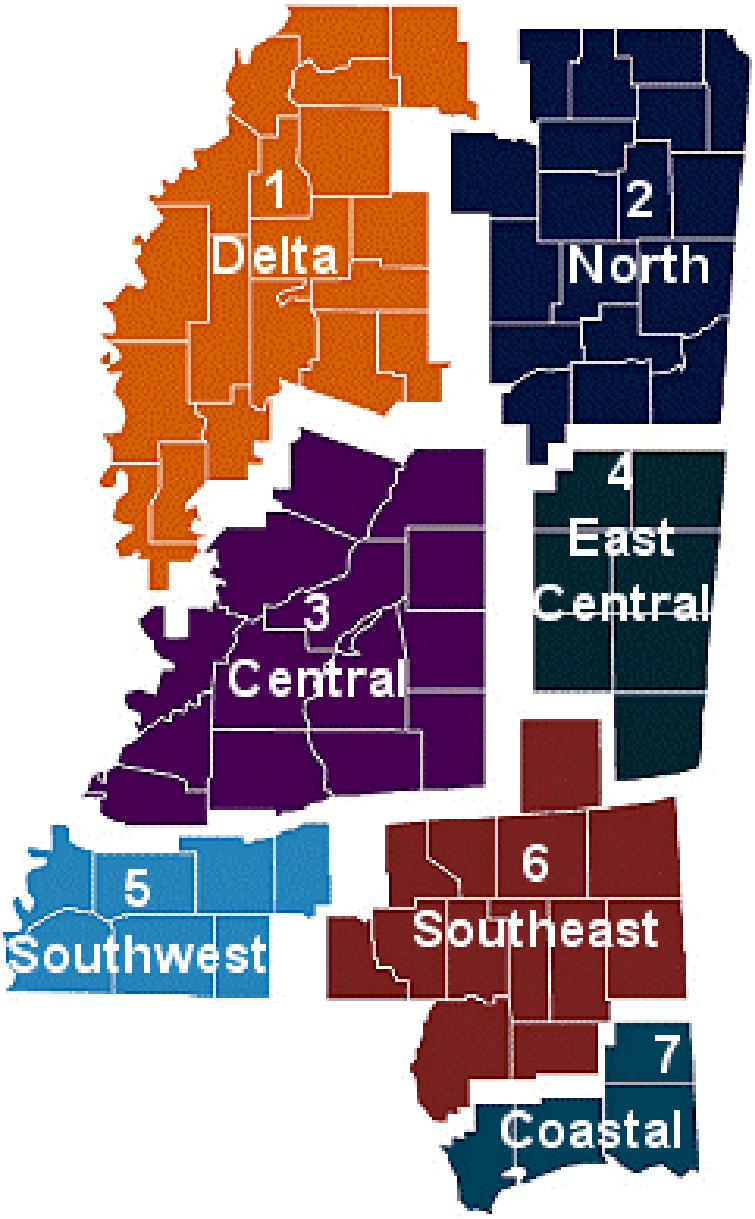
2003

MISSISSIPPI TRAUMA REGIONS



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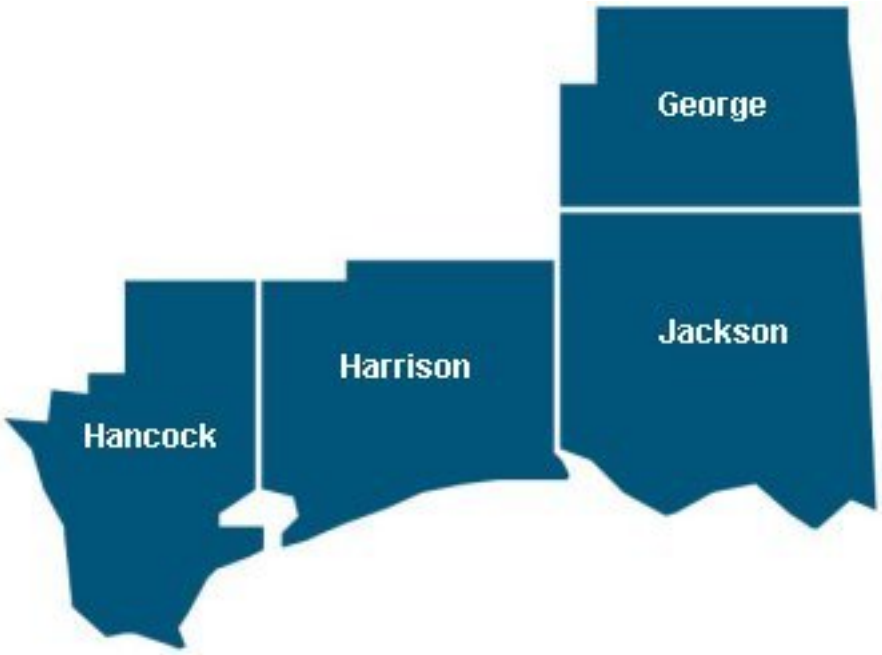

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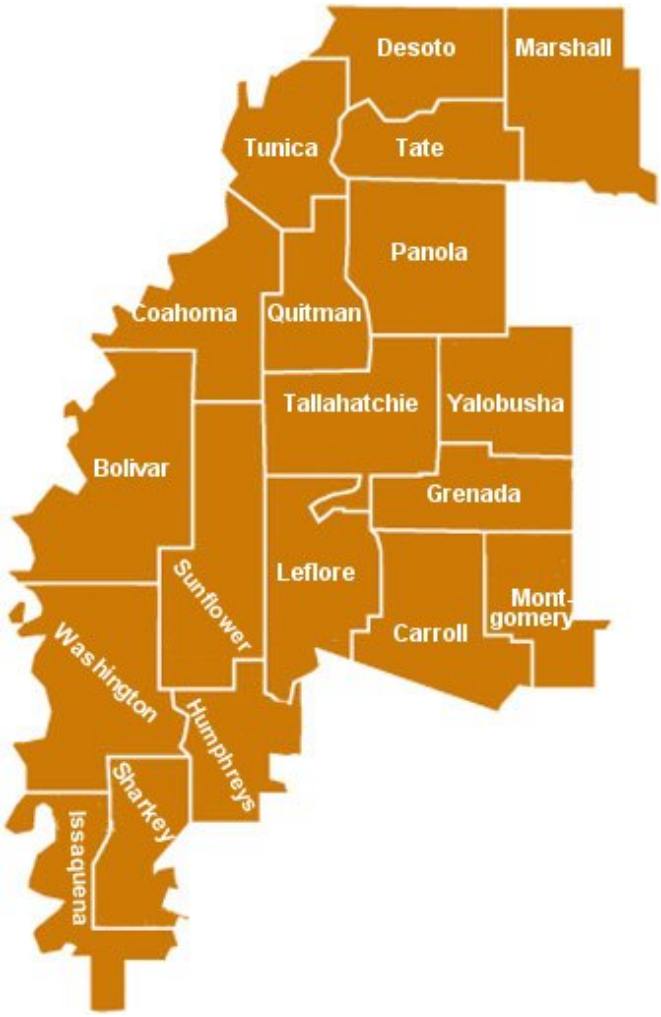

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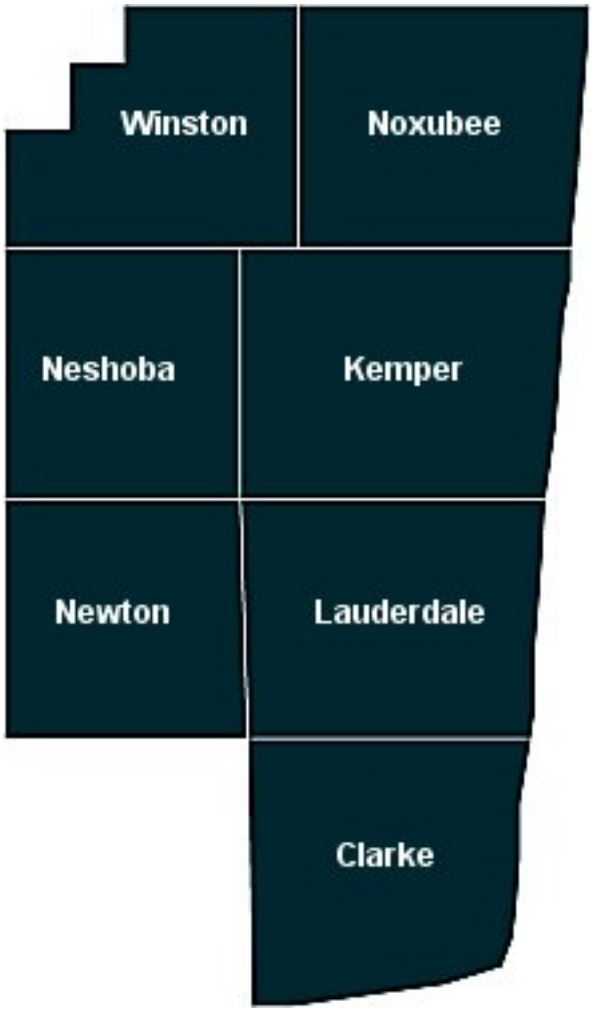

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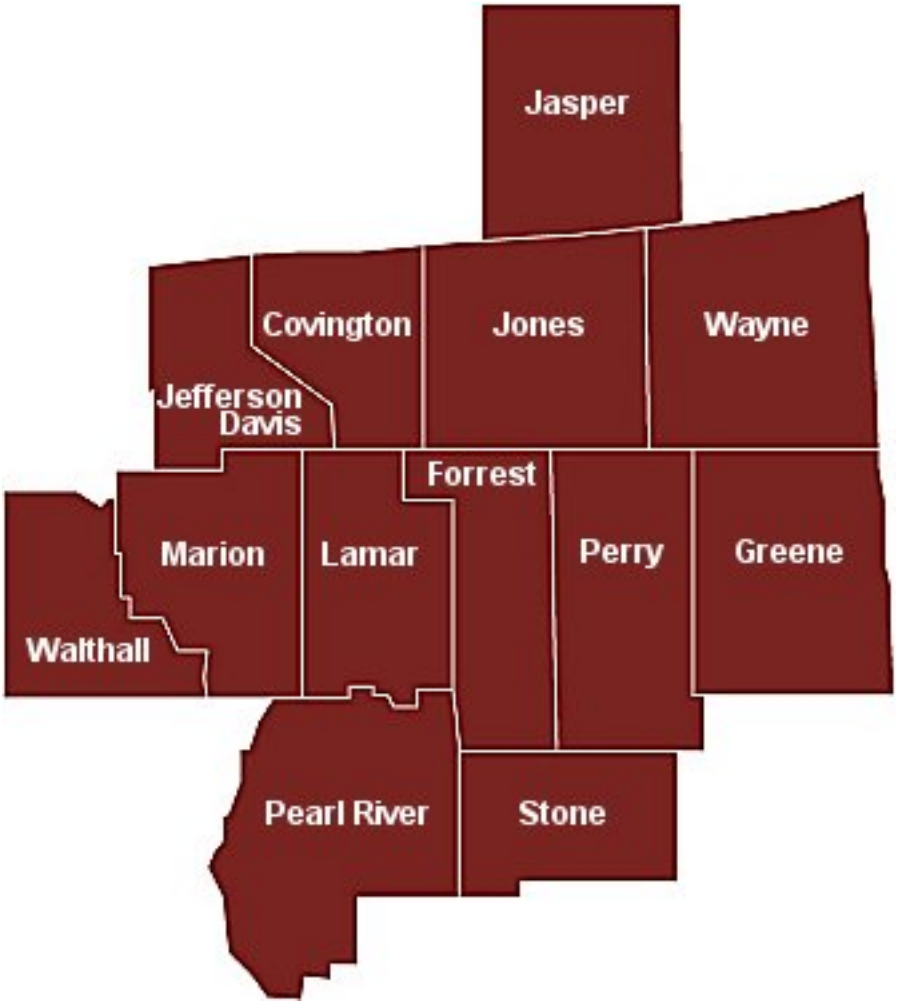

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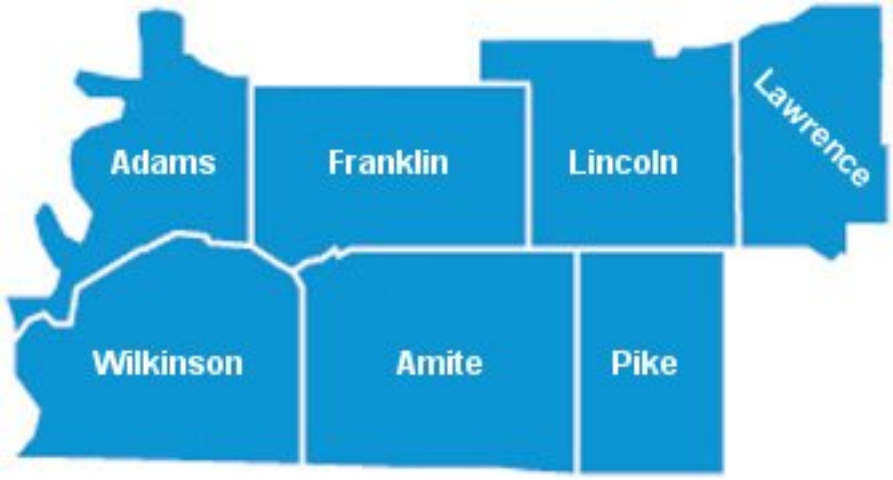


ELIGIBILITY FOR REIMBURSEMENT FROM FUND

Trauma centers designated by BEMS are eligible to participate in the Fund. See definition below.

For claim year 2004, the following physician specialties were eligible to participate in the Fund:

- General/trauma surgeons;
- Orthopedic surgeons;
- Neurosurgeons; and
- Anesthesiologists who are financially affected when the patient chooses not to pay.

The eligible physician must be the attending or admitting physician who provides health care service to a patient whose condition and/or circumstances qualifies the patient for entry into the trauma registry. Services must be delivered at a designated trauma center, and such service must be directly related to the medical treatment of the trauma case.

Anesthesiologists became eligible in the 2001 claim year. Eligible physician specialties are reviewed each year by the MTAC and are subject to change.

Uncompensated trauma care reimbursement will be provided only to designated Level I, II, and III Trauma Centers.

Designated Level IV Trauma Centers shall not receive reimbursement for uncompensated care, however, will receive $10,000 annually for administrative support for participation in the Mississippi Trauma Care System.

Designated Level I, II, and III Trauma Centers that receive complete designation by December 31, 2004, will be eligible to receive 100% of uncompensated reimbursement for claim year 2004. Level I, II, and III Trauma Centers that remain provisionally designated after December 31, 2004 will be eligible to receive only 50% of uncompensated care reimbursement. Trauma Centers that remain provisionally designated due to specialty coverage will be eligible for 100 % uncompensated care reimbursement. A provisional designation does not effect the claims submitted by eligible physicians for reimbursement.

Definitions

Claim Period: Claims may be submitted for eligible services provided between January 1 – December 31 of each calendar year. All hospital and physician claims are based on hospital discharge date. All claims for service provided within this time period must be received within a timeframe to be determined by BEMS. Claims received after this deadline will not be considered for reimbursement.

Designated Trauma Center: A hospital designated by BEMS as a trauma center that provides care to trauma patients. Trauma centers in the Mississippi Trauma System care for a variety of

injured patients. These patients are provided immediate resuscitation and stabilization, and definitive acute care. There are rules and regulations mandated by the MSDH with which compliance is necessary to be a designated trauma center.

Trauma patients are cared for at these trauma centers regardless of that patient's financial status. The multi-disciplinary approach follows the patient throughout the continuum of care from pre-hospital to rehabilitation.

Trauma centers work to continually improve critical elements of trauma care. The trauma centers are required to maintain a trauma registry with up-to-date information. This registry provides assistance in the performance improvement process. It is uploaded twice a year to BEMS for statistical analysis and once a year for uncompensated care reimbursement.

Effective in 2004, Mississippi has 69 participating hospitals in the trauma care network, ranging from Level I to Level IV trauma centers.

Trauma Centers Levels	**Number of Hospitals**
I	1 in-state; 1 out-of-state*
II	5
III	8
IV	50

* In the 2002 claim year, Level I hospitals in states contiguous to Mississippi were allowed to become designated trauma centers for the State of Mississippi. The Regional Medical Center of Memphis, Tennessee (the MED), became the first non-Mississippi hospital to become eligible to participate in the Fund, and is the only non-Mississippi trauma center eligible to participate in the Fund. Non-Mississippi hospitals may only submit claims for trauma patients injured in Mississippi. This policy is frequently reviewed and is subject to change.

Due Diligence: This term is related to collection of payments due for trauma cases. A provider must apply its existing internal collection policies to trauma cases prior to determining that the case is uncompensated and submitting it for reimbursement from the Fund. Trauma claim forms contain an affidavit that providers must sign attesting to the compliance of internal collection policies. **Note: Providers may be required to cease internal collection procedures earlier than is stated in their policies in order to meet OEPR deadlines for submission of claims.**

Eligible Physician: The attending or admitting trauma/general surgeon(s), orthopedic surgeon(s), neurosurgeon(s) or anesthesiologist(s) who provides health care service to a qualified trauma patient at a designated trauma center, and such service is to be directly related to the medical treatment of the trauma case. Anesthesiologists must be financially affected if the trauma patient chooses not to pay for delivered trauma care. Anesthesiologists who receive a fixed salary from a trauma center or who are paid based on a percentage of gross charges are examples of anesthesiologists who would not be eligible to participate in the Fund.

Inpatient: Any trauma patient who meets trauma registry inclusion criteria; who is included in the trauma registry; and who is admitted as an inpatient to a trauma center.

Non-inpatient: Any trauma patient who meets trauma registry inclusion criteria; who is included in the trauma registry; and who receives care at a trauma center and is not admitted as an inpatient. This includes:

A. Any trauma patient who presents at a trauma center and is treated and released without an inpatient stay;
B. Any trauma patient who is transferred in to a trauma center from an outside facility and released without being admitted as an inpatient;
C. Any trauma patient who is transferred to an outside facility from a trauma center;
D. Any trauma patient who presents at a trauma center regardless of transfer status, and expires in the hospital without being admitted as an inpatient; and
E. Any trauma patient who presents at a trauma center, but leaves against medical advice (AMA).

Physician Charges: The gross charges for the professional component of eligible physicians associated with treatment of uncompensated trauma cases. This does not include laboratory, x-ray, facility fees, drug or supply charges, hospital visits included in a global surgical fee, or any other charges that do not fall under the scope of the professional component.

Trauma: A term derived from the Greek word "wound." BEMS has developed the following criteria for inclusion of a patient's condition into the trauma registry:

All state designated patients must have a primary diagnosis of ICD-9 diagnosis code 800-959.9;

Only burn patients with an ICD-9 Code of 940-949 qualify for inclusion into the trauma registry. Qualifying burn patients must also meet one of the following criteria.

Plus any one of the following:

- Transferred between acute care facilities (in or out)

  Any patient that has sustained an injury (ICD-9: 800.0 - 959.9) and is referred from a trauma center or transferred to a trauma center qualifies for inclusion into the trauma registry.

- Admitted to critical care unit (no minimum days).

  Any injury that a patient has sustained in which the patient is admitted to a critical care unit qualifies for inclusion into the trauma registry.

- Hospitalization for three or more calendar days.

  Any trauma patient hospitalized for three or more calendar days due to injuries sustained qualifies for inclusion into the trauma registry.

- Died after receiving any evaluation or treatment.

All deaths due to an injury that receive an evaluation or treatment in the Emergency Department qualify for inclusion into the trauma registry.

- Admitted directly from Emergency Department to Operating Room for major procedure, excluding plastics or orthopedics procedures on patients that do not meet the three day hospitalization criteria.

  Any trauma patient that is admitted directly from the Emergency Department to the Operating Room for a major procedure qualifies for inclusion into the trauma registry. Plastics and/or orthopedic procedures that do not meet one of the other criteria for inclusion into trauma registry are EXCLUDED and do not quality for inclusion into the trauma registry.

- Triaged (per regional trauma protocols) to a trauma hospital by pre-hospital care regardless of severity.

  Any trauma patient that is triaged to a trauma center by pre-hospital care providers, per regional trauma protocols, qualifies for inclusion into the trauma registry. Documentation verifying that this criteria was used must be present in the patient's hospital chart to qualify for inclusion.

- Treated in the Emergency Department by the trauma team regardless of severity of injury.

  Any trauma patient that arrives at a trauma center and is treated by a trauma team as delineated by hospital policy qualifies for inclusion into the trauma registry. Documentation verifying a trauma team activation and response must be present in the patient's hospital chart to qualify for inclusion.

The following primary ICD-9 diagnosis codes are excluded and should NOT be included in the trauma registry:

- ICD9Code 905-909 (Late effects of injuries)

  Late Effects of Injuries, Poisonings, Toxic Effects, and Other External Causes.

- ICD9Code 930-939 (Foreign bodies)

  Effects of Foreign Body Entering Through an Orifice.

- Extremities and/or hip fractures from same height fall in patients over the age of 65.

Trauma Care Facility (or "Trauma Center"): A hospital that has been designated by BEMS to perform specified trauma care services within a Trauma Care Region pursuant to standards adopted by BEMS. Participation in this designation by each hospital is voluntary.

Trauma Patient: A patient who presents at a trauma center; whose condition is qualified for entry into the hospital's Trauma Registry, as defined by BEMS; and who is included in the Trauma Registry. A patient *must* be included in the Trauma Registry in order to be considered for reimbursement from the Fund.

Uncompensated Care: Care for which the provider decides not to collect payment because of the patient's inability to pay. A claim is considered to be uncompensated if, after the provider's due diligence to collect monies due, total payment from any source (including third party payors) of 5 percent or less has been made on the total trauma-related gross charges. ***Note: Claims paid in any part by Medicaid cannot be submitted for reimbursement from the Fund.***

FUND ALLOCATION PROCESS

The Fund is allocated based on relative values, assigned by the Center for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)), for DRG's (hospitals – see below) and CPT codes (physicians – see below). Relative values were chosen for this allocation system because they are standard among hospitals and physicians in Mississippi, unlike gross charges or cost structures, which can vary widely among providers. They are also published and utilized by Medicare, a program in which the majority of physicians and hospitals in Mississippi participate. The relative weight in effect for that provider at the time of service is used for allocation calculations.

DRG's

DRG's, or Diagnosis Related Groups, are groupings of Medicare inpatients used to determine the payment the hospital will receive for the admission of that type of patient. The group definition is based on diagnoses, procedures, presence of complications or comorbidity, age, sex and discharge disposition. There are over 500 DRG's, which are reviewed and assigned a new relative weight, effective October 1 each year. Therefore, the 2002-03 DRG relative weights are effective for discharge dates in January – September 2002; 2003-04 DRG relative weights are effective for discharge dates in October – December 2003. These relative weights are published annually in the *Federal Register* and are available on the Internet at www.cms.hhs.gov.

The relative value system for DRG's does not include a value for non-inpatient cases. Therefore, eligible non-inpatient trauma cases will each receive a calculated "relative weight" of 0.20. This calculated weight is reviewed annually and is subject to change.

CPT Codes

Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. In order to establish a Medicare fee schedule for participating physicians, CMS established relative weights for CPT codes using its Resource-Based Relative Value System (RBRVS). This three-part system includes a weight for the work involved in the delivery of the service; the practice cost of the service; and a factor for malpractice. After applying the Geographic Practice Cost Index (GPCI) for Mississippi to each factor, the total weight is multiplied by a common conversion factor to calculate the Medicare allowable fee for each CPT code. Medicare participating physicians in Mississippi are all paid under the same Medicare fee schedule.

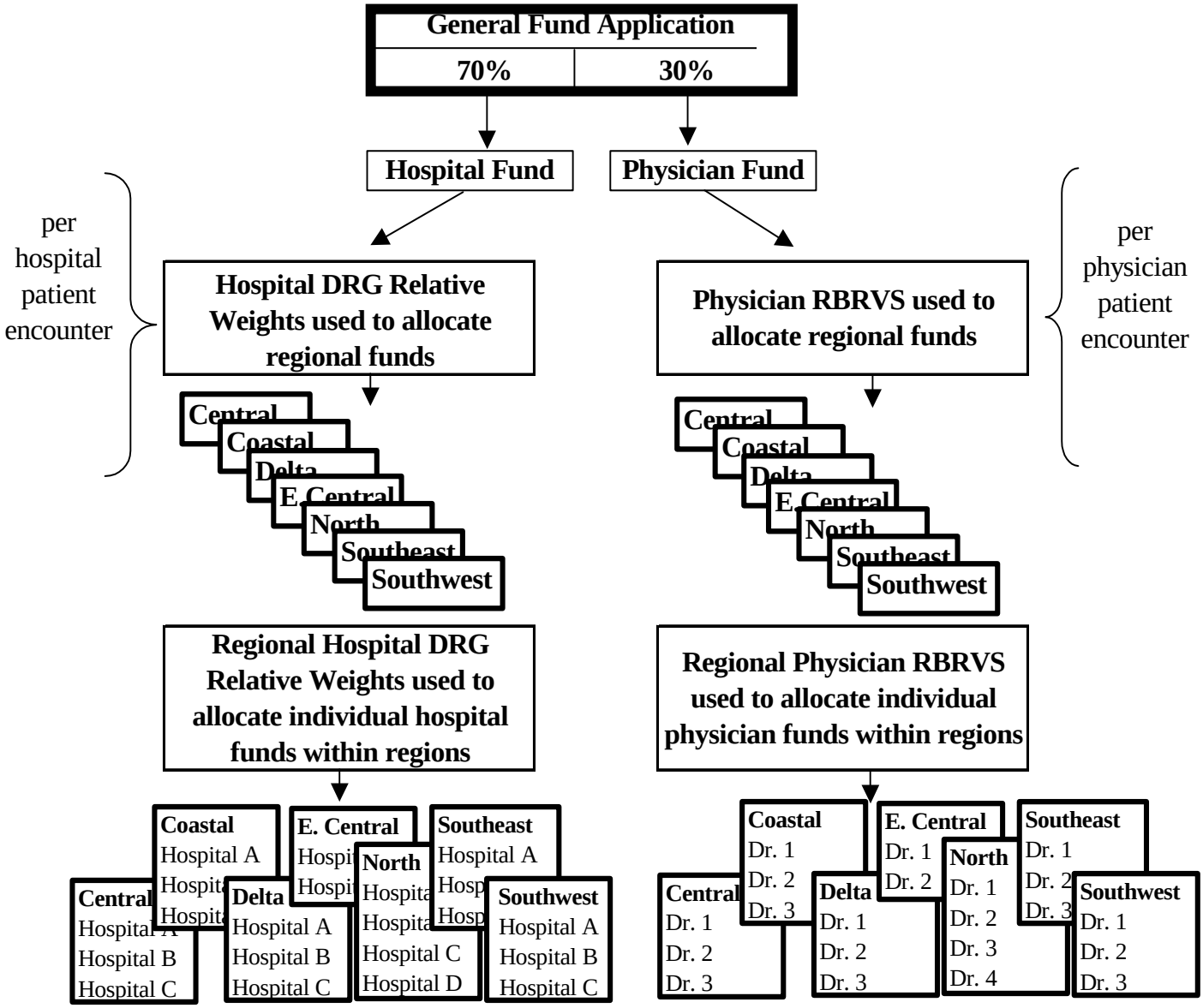
Mississippi Medicare fee schedules and RBRVS information are updated by CMS effective January 1 of each year, and are available from the *Federal Register*, at www.cms.hhs.gov, or from Cahaba Government Benefit Administrators, the Medicare Part B carrier for Mississippi.

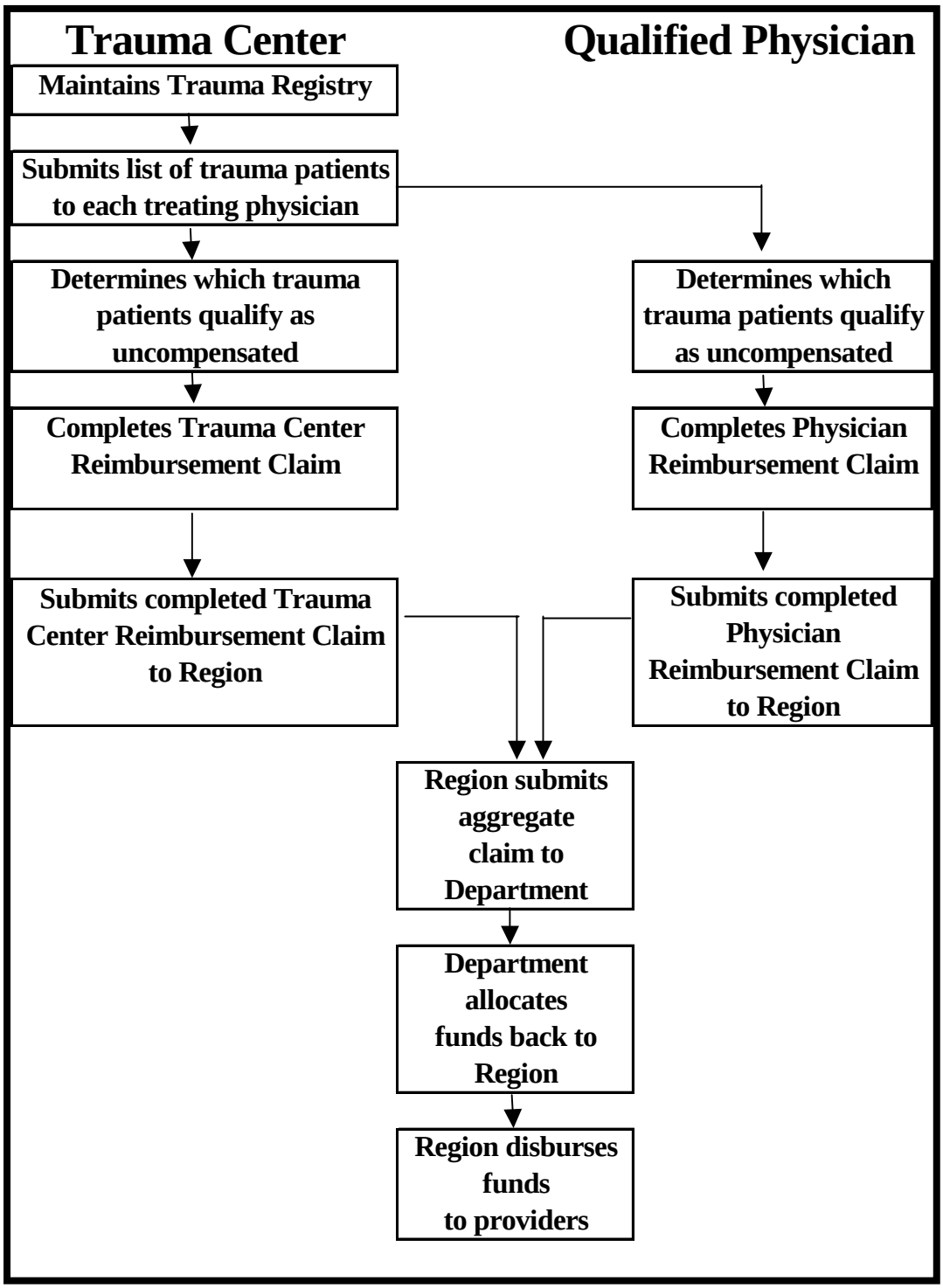
ASA Codes

Anesthesiologists typically utilize a coding system developed by the American Society of Anesthesiologists (ASA), rather than CPT codes. Each ASA code has an assigned Basic Unit Value, which includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. Time units, calculated in 15-minute increments (i.e., 30 minutes equals 2 time units), are added to the Basic Unit Value and multiplied by the anesthesiology conversion factor calculated each year by CMS, to determine the amount of Medicare reimbursement. Medicare reimbursement amounts are adjusted as required by submitted modifiers.

The portion of the Fund designated for physicians is equalized between surgeons and anesthesiologists to insure that all qualified physicians receive the same reimbursement level as related to the Medicare fees that were in effect at the time of service.

Reimbursement Paper Flow




Trauma Center
Qualified Physician
Maintains Trauma Registry
Submits list of trauma patients to each treating physician
Determines which trauma patients qualify as uncompensated
Determines which trauma patients qualify as uncompensated
Completes Trauma Center Reimbursement Claim
Completes Physician Reimbursement Claim
Submits completed Trauma Center Reimbursement Claim to Region
Submits completed Physician Reimbursement Claim to Region
Region submits aggregate claim to Department
Department allocates funds back to Region
Region disburses funds to providers

PROVIDER REIMBURSEMENT PROCEDURES

STEP 1: Trauma Registry

The Fund allocation process starts with the Trauma Registry. Trauma centers typically designate a Trauma Registrar who is responsible for maintaining the Registry, a database software called *Trauma One*. Installation and training for *Trauma One* is provided by BEMS to designated trauma centers.

Note: Trauma Registrars are advised to populate all registry fields, including every physician who works on a trauma case, regardless of the physician's eligibility for reimbursement from the Fund. MTAC frequently reviews the list of eligible specialties, and Registrars may be called upon to provide information for study data.

A. Determine Patient's Eligibility for Trauma Registry. This should be done in a timely manner throughout the year. Responsibility typically resides with Trauma Registrar and may be overseen by a supervisor and/or review committee.

B. Compile Registry List for Hospital and Physicians. At the end of the calendar year (and preferably more frequently throughout the calendar year), the Registrar compiles a list of qualified trauma patients **with discharge dates of January – December of the claim year** from the Registry. (Patients meet registry requirements based on the clinical situation. Payment status has nothing to do with qualification for the Registry.) This list is submitted to the hospital's business office to determine if the patient's case meets the definition of uncompensated care. The Registrar must also send a periodic list of Trauma Registry patients to each qualified physician who delivered trauma care to the patient. The Registry list must contain at a minimum:

1. Trauma Registry number assigned by the registry software;
2. Patient name, date of birth, social security number, and/or other identifying data;
3. Date patient presented at hospital; and
4. Discharge date (must be in claim/calendar year).

Individual hospitals and physicians may request additional information. Registrars should send a complete list of patients, regardless of their ability to pay. Registrars that utilize only the "indigent" category from the registry will not have a complete list, because of the difference in "uncompensated" and "indigent." Many cases that meet the definition of "uncompensated" (payment of 5 percent or less on trauma-related charges) may in fact have third-party insurance and/or means to pay.

All cases submitted for reimbursement from the Fund must qualify for inclusion and be included into the Trauma Registry of a designated trauma center.

STEP 2: Determination of "Uncompensated Care"

The hospital and physicians make independent determinations regarding uncompensated care. For example, a trauma case may meet the definition of "uncompensated" for the hospital (the hospital received payment of 5 percent or less on the gross trauma-related charges), but the treating physician was paid over 5 percent. In this example, the hospital may submit the case for reimbursement from the Fund, but the physician may not.

A. Determining Trauma-Related Charges. Only the trauma-related charges should be considered when reviewing trauma cases for eligibility for reimbursement from the Fund. The following physician services cannot be submitted for reimbursement and should not be included in the calculation for "trauma-related charges":

1. Office visits or consults;
2. Laboratory services;
3. Radiology services;
4. Drugs or supplies;
5. Hospital visits that are included in the global surgical period, as defined by Medicare billing guidelines;
6. Qualifying circumstances codes (99100 – 99140);
7. CRNA services; and
8. Physical status codes (P1 – P6).

Hospitals may not include ambulance or emergency room physician charges.

Providers are allowed to continue to collect from the patient or other source for services that cannot be submitted for reimbursement from the Fund.

B. Collections. A provider must apply its own existing internal collection policies to trauma cases prior to determining that the case is uncompensated and submitting it for reimbursement from the Fund. "Due diligence" must be exercised and providers should document that internal collection policies have been consistently applied to trauma cases. Trauma claim forms contain an affidavit that providers must sign attesting to the compliance of internal collection policies, among other things.

C. Writing Off Balances. After a trauma case has met the definition of "uncompensated," trauma charges must be written off prior to submitting the case to the Fund for reimbursement. Providers may write off the balance to collections, bad debt or another account as long as the charges are removed from active accounts receivable in the detailed general ledger. Internal collection efforts, including letters and phone calls, must also cease.

Note: Providers may be required to cease internal collection procedures earlier than stated in their policies in order to meet BEMS deadlines for submission of claims. For example, a hospital may have a policy to make internal collection efforts over a six-month period before writing off the charges to bad debt. The deadline for claims submission is March - April of the following year. Because charges must be written off prior to submission of the claim, some charges incurred in November and/or December of the claim year may not be able to go through the entire six-month internal collection cycle prior to being written off by the provider. BEMS is aware of this exception to the due diligence policy. Providers will not be penalized for early termination of internal collections in order to meet BEMS claim deadlines. See Claims Submission Calendar below.

Note: Any amount collected on a trauma account by an outside collection agency after the claim has been reimbursed from the Fund must be considered in its entirety when calculating the amount to be refunded to the Trauma Region. For instance, a collection agency collects $200 on a trauma account and sends the provider 50 percent, or $100, of the amount collected based on their service agreement. The amount previously reimbursed on the account from the Fund is $150. The provider must refund the lesser of the two amounts, which in this case would be the entire $200 collected from the collection agency, even though only $100 was received by the provider.

Claims Submission Calendar

January	Claim forms available for prior calendar year
Mid- to late March	Paper claims due
First week of April	Electronic claims due
May 2-4	Regional claims due to BEMS
June 30	State's fiscal year ends; funds disbursed to regions
September 30	*Providers receive reimbursement and "EOB's" from regions

* Regions must distribute reimbursement monies to providers within 90 days of receipt of funds from BEMS. EOB's provided by Horne CPA Group will either accompany the funds or be available on-line at the time of the distribution.

Sample claim forms for each provider type are available in the Appendices at the end of this manual.

STEP 3: Completing the Claim Form

BEMS has contracted with Horne CPA Group to administer the reimbursement process. The firm has developed a web-based form submission process that can be accessed at www.hcpag.com. Providers enter their data into the system, and, while special programming eliminates many common errors, accuracy of data submission is the sole responsibility of the provider. The deadline for electronic claims submission is usually two to four weeks later than for paper claims.

Paper claims are also available for fax or mail submission to Horne CPA Group. Identical data is required on both the paper and electronic claim form for each provider type. Horne CPA Group sends a faxed draft to providers, which must be reviewed, corrected (if necessary), and returned within a specified timeframe. Horne CPA Group representatives who enter data from paper claims cannot be held responsible for illegible or inaccurate data either submitted by providers on paper claims, or entered into the reimbursement system on the provider's behalf.

Horne CPA Group makes every attempt to insure that all qualified providers are notified of proper procedures and deadlines. A printed newsletter is mailed at least once per year, and numerous e-mail notifications and reminders are sent throughout the claim processing period. Hospitals and regional directors are actively involved in notification and reminders to physicians, but it remains the provider's responsibility to insure that claims are submitted properly and timely. **No claims will be accepted after the published deadlines, regardless of the method utilized for submission.**

Trauma Center Claim Form. The following information is required for trauma centers, effective for the claim year 2004. Please note that the information requested is reviewed annually and is subject to change.

1. Beginning and ending date of service: Beginning date of service is the day the qualified trauma patient presents at the hospital. Beginning date of service can be in the year prior to the claim year. Ending date of service is the day the patient is released from the hospital, and must be in the claim year.

2. Trauma registry number: This is the number assigned to the patient by the registry software. No patient names or other identifying information may be submitted.

3. DRG or Non-IP:
   A. DRG: If the trauma patient (see Page 13 for definition) is admitted as an inpatient to the hospital, please use the final DRG assigned by the hospital for the patient's stay.
   B. Non-IP: Non-Inpatients are trauma patients that present at a designated trauma center, but are not admitted. This includes:
      a. Any trauma patient who presents at a trauma center and is treated and released without an inpatient stay;
      b. Any trauma patient who is transferred in to a trauma center from an outside facility and released without being admitted as an inpatient;
      c. Any trauma patient who is transferred to an outside facility from a trauma center, being admitted into the outside facility as an inpatient;
      d. Any trauma patient who presents at a trauma center regardless of transfer status, and expires in the hospital without being admitted as an inpatient; and
      e. Any trauma patient who presents at a trauma center, but leaves against medical advice (AMA).

4. E-Code from Registry: Emergency codes are assigned by the Trauma Registrar and are formatted as E-XXXX. Please do not use ICD-9 (diagnosis) codes.

5. Type of Injury: The three types of trauma injury are blunt, penetrating, and burn.

6. Trauma Team Activation: The answer to this yes/no question must be documented in the medical record.

7. Non-IP Case Result: Only one of three options for Non-IP case resolution may be selected: Transferred, Released, or Expired. Please do not use other terminology in this column.

8. Gross Charges: Total gross trauma-related charges.

9. Collections: Total collections for trauma case; must be 5 percent or less of total trauma-related charges.

10. Affidavit: Claim cannot be processed without signed affidavit. On-line users are prompted to print out affidavit, sign it, and mail or fax it to Horne CPA Group. The affidavit must be signed by a person in the practice authorized to contractually agree to the following statement:

    I certify that each case listed herein clinically qualifies for the Trauma Registry; that the hospital has complied with its collection policies; that due diligence has been exercised in the attempt to collect monies owed for these accounts; that the cases listed herein qualify as uncompensated as defined in the policies established by the Department; and that all related account balances have been written off in full as of the date of this submission.

Surgeon Claim Form. The following information is required for qualified surgeons, effective for the claim year 2004. Please note that the information requested is reviewed annually and is subject to change.

1. Date of Service: May be in prior or current claim year. Only patients with hospital discharge dates from January – December of the current claim year may be included in the surgeon's claim for reimbursement.

2. Trauma Registry Number: This is the number assigned to the patient by the registry software. No patient names or other identifying information may be submitted.

3. CPT Code: List each allowed CPT code for services delivered to trauma patient. Disallowed or invalid CPT codes will not be considered, and charges to invalid and/or disallowed CPT codes will be deleted from trauma-related charges.

4. Modifier: Include modifiers according to Medicare billing guidelines.

5. Description: The CPT code description is provided by Horne CPA Group.

6. RBRVS and Medicare Fee: Effective for the time of service, this information is also provided by Horne CPA Group.

7. Gross Charges: Total amount of gross trauma-related charges.

8. Collections: Total amount collected on trauma case; must be 5 percent or less of total trauma-related charges.

9. Affidavit: Claim cannot be processed without signed affidavit. On-line users are prompted to print out affidavit, sign it, and mail or fax it to Horne CPA Group. Must be signed by a person in the practice authorized to contractually agree to the following statement:

   I certify that to the best of my knowledge these submitted cases are clinically qualified for the Trauma Registry as defined by the Department. I further certify that the practice has complied with its collection policies; that due diligence has been exercised in attempting to collect monies owed for these accounts; that the cases listed above qualify as uncompensated as defined by the policies established by the Department; and that all related account balances have been written off in full as of the date of this submission.

Anesthesiologist Claim Form: The following information is required for qualified anesthesiologists, effective for the claim year 2004. Please note that the information requested is reviewed annually and is subject to change.

A **qualified anesthesiologist** is an anesthesiologist who is financially affected when the trauma patient chooses not to pay. Examples of ineligible anesthesiologists include (a) those who are paid a fixed salary, and (b) those are paid a percentage of gross charges. Entities that employ anesthesiologists are not eligible to submit claims on behalf of their employed anesthesiologists.

1. Date of Service: May be in prior or current claim year. Only patients with hospital discharge dates from January – December of the current claim year may be included in the surgeon's claim for reimbursement.

2. Trauma Registry Number: This is the number assigned to the patient by the registry software. No patient names or other identifying information may be submitted.

3. ASA Code: American Society of Anesthesiologists code that corresponds with anesthesiology service delivered. If service delivered has no assigned ASA code, a CPT code may be used (i.e., CPT 36489 – CVP line; CPT 36620 – Arterial line). Surgical codes submitted without proper ASA code will not be considered.

4. Modifier: Include modifiers according to Medicare billing guidelines. CRNA modifiers (QX, QZ, G8) are not allowed.

5. CPT Code: List each allowed CPT code for services delivered to the trauma patient. Disallowed or invalid CPT codes will not be considered, and charges to invalid and/or disallowed CPT codes will be deleted from trauma-related charges.

6. Base Units: Provided by Horne CPA Group.

7. Time Units: Anesthesiologists should provide time units for each ASA code in **units, not minutes**.

8. Medicare Fee: This information is provided by Horne CPA Group. Anesthesiologists' Medicare fee is calculated by adding base units and time units, then multiplying the sum by the CMS conversion factor for anesthesiologists in effect at the time of service.

9. Gross Charges: Total amount of gross trauma-related charges.

10. Collections: Total amount collected on trauma case; must be 5 percent or less of total trauma-related charges.

11. Affidavit: Claim cannot be processed without signed affidavit. On-line users are prompted to print out affidavit, sign it, and mail or fax it to Horne CPA Group. The affidavit must be signed by a person in the practice authorized to contractually agree to the following statement:

    I certify that to the best of my knowledge these submitted cases are clinically qualified for the Trauma Registry as defined by the Department. I further certify that uncompensated care directly impacts my personal compensation, that the practice has complied with its collection policies; that due diligence has been exercised in attempting to collect monies owed for these accounts; that the cases listed above qualify as uncompensated as defined by the policies established by the Department; and that all related account balances have been written off in full as of the date of this submission.

Note: Other codes that will not be considered are qualifying circumstances codes (99100 – 99140) and physical status codes (P1 – P6).

RECEIVING MONIES FROM THE FUND

Horne CPA Group is required to provide Fund allocation information to the State of Mississippi by May 2 for the previous claim year. The State releases Fund monies to the Trauma Regions by June 30 for the previous claim year. MTAC requires that Regions must disburse funds to providers within 90 days of receiving them from the State. Providers should expect to receive a check **from the Trauma Region** by September 30 for the previous claim year.

EOB's: Along with a check from the appropriate trauma region, providers also receive from Horne CPA Group an "Explanation of Benefits," or EOB. This EOB details to the provider how to allocate the reimbursement to each patient's account. EOB's are available on-line. Those without on-line capabilities will receive paper copies in the mail. These EOB's **will not necessarily** accompany the check, since they are coming from different sources.

Required Accounting Procedures: Formerly listed as "suggested" accounting procedures, the following procedures are required to allocate trauma funds, alert posters to additional payments on accounts (see **Reimbursing the Fund** below) and expedite audits:

1. Payments from the Fund **must** be posted to individual accounts as detailed on the EOB;

2. Segregate trauma accounts into separate financial class in bad debt classification;

3. Use flash or pop-up notes in the management information system to alert posters;

4. Post reimbursement as collection balance, just like any other type of payment;

5. Post entire amount, even if greater than charges. Adjust to zero, if necessary; and

6. Run periodic reports on financial class to check for other payments.

Occasional rounding issues may cause the total patient allocations to be a few cents to a few dollars different from the total reimbursement. If this occurs, minor accounting adjustments can be made and documented to allow account balances to foot properly. If the rounding differences are more than a few dollars, the provider should contact Horne CPA Group.

Paying Back the Fund: Occasionally providers will receive payment on a case that was previously reimbursed by the Fund. If this happens, the provider is obligated to repay the Fund within 30 days of receipt of the secondary payment. Because Fund monies flow from the State to the Region to the provider, they must flow back the same way. Therefore, the provider must reimburse the ***Region*** the lesser of the two amounts within 30 days:

a. Amount paid by patient or insurance; and
b. Amount reimbursed through Fund.

Exception: If Medicaid pays *any* amount on a case previously reimbursed from the Fund, the amount reimbursed from the Fund must be refunded to the Region in its entirety.

The check made out to the Region must be accompanied by a cover letter, which includes:

a. Trauma registry # and date(s) of service;
b. Amount of payment received;
c. Amount of original reimbursement from Fund; and
d. Amount of enclosed check.

There is no statute of limitations for this requirement. Cases reimbursed from the Fund since its inception in 1999 are subject to this policy. Providers must show ongoing efforts to comply with this regulation (see **Required Accounting Procedures**) and documentation of compliance (copies of checks and cover letters, etc.).

Note: Checks should ONLY be sent to the appropriate Trauma Region and SHOULD NOT be sent to Horne CPA Group.

Audit: The Fund is allocated by the Mississippi Legislature, and any provider receiving reimbursement is subject to audit by OEPR. Each hospital and physician can expect to be audited within two years after receiving monies from the Fund. Providers must present documentation of all activities related to internal collections; analysis, preparation and submission of claims; receipt and posting of monies; and ongoing efforts to comply with refund requirements if payment is received on previously-reimbursed cases (see above). Providers found to be in violation of BEMS procedures regarding reimbursement for uncompensated care may be subjected to refunds, fines, and possible elimination of eligibility for Fund participation.

Training Sessions: Horne CPA Group conducts a training session in each Region in January of each claim year. Sessions are publicized in an annual newsletter and individually by Regional directors in each Region. The sessions last approximately one to two hours and contain important information about updates, changes, and deadlines for submitting claims to the Fund for reimbursement. Providers are urged to send any personnel involved in the claims process to these informative sessions. Providers may attend any session in any Region.

FREQUENTLY ASKED QUESTIONS

1. **What are the basic qualifications for a hospital to receive reimbursement from the Mississippi Trauma Care Trust Fund for uncompensated trauma care?**

   Hospitals must be:
   A. In one of the seven designated trauma regions in the State of Mississippi;
   B. Designated as a trauma center (levels I - IV) by OEPR; and
   C. Utilizing a trauma data collection system approved by OEPR.

2. **The Mississippi State Legislature recently passed legislation allowing Level I trauma centers in states contiguous with Mississippi to participate in the State's Trauma Network. Will they also be allowed to submit claims for reimbursement from the Mississippi Trauma Care Trust Fund (the Fund)?**

   To date, yes, if the Trauma Center receives proper designation from OEPR as a Level I Trauma Center. The only Level I Trauma Center outside the State of Mississippi that is currently allowed to participate in the Fund is The Regional Medical Center at Memphis (The Med), which is officially a member of the Delta Trauma Care Region. At present, qualifying hospitals outside the State can only submit claims for reimbursement from the Fund for patients who were injured in Mississippi.

3. **Where do I go for assistance in determining if a patient qualifies for the Trauma Registry?**

   BEMS employs Trauma Program Managers who can help you interpret the clinical data to determine if the patient qualifies for the Trauma Registry. They can be reached at (601) 576-7380.

4. **Does a patient have to meet the criteria and be entered into the hospital's Trauma Registry for a hospital or physician to submit the claim for reimbursement?**

   Yes. Every claim submitted to BEMS must qualify and be entered into the hospital's Trauma Registry first. Once the case has been entered into the Trauma Registry, the account status can be reviewed to determine if it meets the definition of "uncompensated." If it does, then it can be submitted for reimbursement.

5. **What is the definition of "uncompensated care" for qualified hospitals and physicians?**

   Uncompensated Care: Care for which the provider decides not to collect payment because of the patient's inability to pay. A claim is considered to be uncompensated if, after the provider's due diligence to collect monies due, total payment from any source of 5 percent or less has been made on the total trauma-related gross charges.

Providers must show due diligence in attempting to collect balances due. Trauma-related charges must be *written off in full* prior to submitting the claim for reimbursement from the Mississippi Trauma Care Trust Fund.

Any claim for reimbursement of uncompensated care must first be qualified for the Trauma Registry. No claims for care delivered to patients outside the registry may be submitted for reimbursement.

Exception: ***Claims paid in any part by Medicaid cannot be submitted for reimbursement from the Fund.***

6. We use an outside collection agency. Must we still send Trauma claims for collection after they have been submitted for reimbursement?

BEMS does not mandate outside collections after a claim has been written off and submitted for reimbursement. However, any amount collected by an outside collection agency on an account that was previously reimbursed by the Fund must be considered in its entirety when determining the amount to be reimbursed to the Region.

For instance, a collection agency collects $200 on a trauma account and sends the provider 50 percent, or $100, of the amount collected based on their service agreement. The amount previously reimbursed on the account from the Fund is $150. The provider must refund the lesser of the two amounts, which in this case would be the entire $200 collected from the collection agency, even though only $100 was received by the provider.

7. Is the Trauma Reimbursement Process HIPAA-compliant?

This registry and related processes are compliant with all existing Trauma regulations of the Mississippi Department of Health and BEMS. Rules related to the disclosure of protected health information for purposes of the promotion of public health in current HIPAA regulations have also been followed.

8. Which physicians qualify under the guidelines of participation in the Fund?

- General/trauma surgeons;
- Orthopedic surgeons;
- Neurosurgeons; and
- Anesthesiologists who are financially affected when the patient chooses not to pay.

9. Are ER physicians, radiologists, pathologists, or hospital-based air/ground ambulance services allowed to claim reimbursement for uncompensated care from the Fund?

No. Each year the Mississippi Trauma Advisory Committee (MTAC) assesses the process and makes recommendations regarding provider participation for future years.

10. How are the funds allocated?

The Fund is divided using a 70:30 ratio: 70 percent of the entire Fund is allocated to the hospitals and 30 percent to the qualifying physicians.

Hospitals: The funds are allocated among Regions and among hospitals within a Region based on the percentage of the hospital's DRG total relative weight to the total DRG relative weights submitted by the hospital population.

Surgeons: The funds are allocated among Regions and among physicians within a Region based on the percentage of the physician's total RBRVS amount to the total RBRVS amount submitted by the surgeon population.

Anesthesiologists: The funds are allocated among Regions and among anesthesiologists within a Region based on a formula that uses Medicare fees for anesthesiologists to establish an allocation amount that is equivalent to that of surgeons.

11. What if a Trauma case is a cost outlier?

A cost outlier is a high-cost case that can receive payment that exceeds the DRG payment. Because the DRG payment itself does not directly affect the Trauma Center's reimbursement level, outliers cannot be submitted in the DRG payment information on the *Trauma Center Reimbursement Claim.*

12. What is a non-inpatient?

A non-inpatient is a qualified Trauma patient (see definition on Page 13) who is not admitted to the hospital. A non-inpatient is typically a patient who:

- Transferred in to/out of a trauma center;
- Was treated and released;
- Left against medical advice (AMA); and
- Expired in the facility prior to admission.

13. If a patient is not admitted, there is no assigned DRG. How do hospitals receive reimbursement for non-inpatients?

A calculated weight of 0.2000 is assigned to non-inpatient cases. This calculation is reviewed each year and is subject to change.

14. Are the forms available electronically?

Yes. BEMS has contracted with Horne CPA Group to administer the reimbursement process. The firm has developed a web-based form submission process that can be accessed at www.hcpag.com. Providers enter their data into the system, and special programming eliminates many common errors. The deadline for electronic claims submission is usually two to four weeks later than for paper claims.

Paper claims are also available for fax or mail submission to Horne CPA Group. Identical data is required on both the paper and electronic claim form for each provider type. Horne CPA Group sends a faxed draft to providers, which must be reviewed, corrected (if necessary), and returned within a specified timeframe. Horne CPA Group representatives who enter data from paper claims cannot be held responsible for illegible or inaccurate data either submitted by providers on paper claims, or entered into the reimbursement system on the provider's behalf.

The affidavit page must be printed, signed, and sent to Horne CPA Group, either by fax or mail.

15. What information is the hospital obligated to provide to the eligible physicians who treated Trauma Registry patients in a claim year?

The hospital should provide to each eligible physician a list from the Trauma Registry of that physician's patients, which should include the Trauma Registry number, patient name, social security number, date of birth or other patient identification information, hospital admission and discharge date. Physicians may request additional information. It is recommended that this information be provided on a monthly or quarterly basis, or as requested by the physician. Trauma Registrars should make every effort to keep Registry information as current as possible so lists can be generated to physicians in a timely manner.

16. Can a patient be qualified as uncompensated by a hospital and not by the treating physician(s), or vice versa?

Yes. It is likely that patients will make significant efforts to pay one provider type and not be able to pay the other. A claim for a patient with only hospitalization insurance (that pays more than 5 percent of the total Trauma-related charges) cannot be submitted for reimbursement by the hospital. If that hospitalization insurance does not cover services provided by the qualified physician and the patient pays 5 percent or less of the physician's Trauma-related charges, the claim could be submitted by the physician for reimbursement.

17. What if a patient has minimal insurance that only pays a small portion of the total charges?

If the total payment from any source (including third party benefits) is 5 percent or less of the total Trauma-related gross charges and the account has been written off as uncollectible, the case may be included in the claim for reimbursement for uncompensated care.

18. Medicaid paid 5 percent or less on a Trauma case. Why can't that case be submitted for reimbursement from the Fund?

Providers who accept Medicaid were required to sign an agreement with Medicaid stating that any payment received by Medicaid would be accepted as payment in full. Therefore, Fund monies cannot be applied to cases paid in any part by Medicaid, even if the payment is 5 percent or less of the total charges.

19. What if the provider writes off the charges and submits the uncompensated case for reimbursement, then later receives partial or full payment on the case?

The provider is obligated to reimburse **the Region**, which will reimburse the Fund, in the amount of the full or partial payment, or the amount that was actually reimbursed for the case from the Mississippi Trauma Care Trust Fund, *whichever amount is less.* The provider is obligated to pay back **the Region** regardless of the length of time between the reimbursement from the Fund and the provider's receipt of payment on the claim. Repayments should be sent within 30 days of receipt of the second payment. A cover letter must be included that contains the following information:

a. Trauma Registry number and date(s) of service;
b. Amount of payment received;
c. Amount of original reimbursement from Fund; and
d. Amount of enclosed check.

Keep all documentation for audit purposes.

Example 1:

The Fund reimburses the hospital $1,000 on a $10,000 case. Three years later, a legal claim is settled and the hospital receives $100 for the case. The hospital must reimburse the region $100, which then reimburses the Fund $100 on the provider's behalf.

Example 2:

The Fund reimburses the hospital $200 on a $1,000 case. Six months later, the patient is deemed to have retroactive medical insurance that pays the hospital $800 on the claim. The hospital must reimburse the region $200.

Exception: If Medicaid makes a payment in any amount on a case that was previously reimbursed from the Fund, the entire amount of reimbursement from the Fund must be sent back to the Region.

Note: Checks should be made out and sent to the Trauma Regions. PLEASE DO NOT SEND MONEY TO HORNE CPA GROUP OR OEPR.

20. Can a provider refuse full or partial payment on a case that has already been reimbursed by the Fund?

No. The provider may not refuse any payments for any Trauma-related care that has been reimbursed by the Fund. The provider must pay back the Region using the guideline described above if any payment is received on a case at any time after the Fund has reimbursed the provider for that case.

21. Is the provider required to notify any entity if a case submitted for reimbursement from the Fund is involved in litigation?

No. If the trauma case meets the definition of "uncompensated," it may be submitted for reimbursement regardless of the legal status. The only obligation a provider has to the Fund after a case has been reimbursed is to pay back the Region using the guideline above for any payments received after the case has been reimbursed from the Fund.

22. Is the provider subject to audits of any type?

Because the Fund is a state-administered fund, providers receiving reimbursement from the Fund are subject to scheduled and unscheduled audits by BEMS. Audits can be expected within two years of receiving reimbursement from the Fund. All documentation related to the Trauma-related care of the patient and financial determinations that caused the provider to classify the case as uncompensated as defined herein must be immediately available for auditors. In the event of an audit, providers must demonstrate a clearly documented audit trail for each claim submitted for reimbursement from the Fund.

23. What if a provider is found to have erroneously or fraudulently submitted cases for reimbursement to the Mississippi Trauma Care Trust Fund?

Providers will be subject to repay the Fund the entire amount of the reimbursement received from the Fund and possible monetary fines and penalties, up to being excluded from future participation in the Fund.

24. What other hospital departments should be involved in the data collection?

In addition to the Trauma Registry coordinator and business office, it is likely that the hospital's medical records, information systems and ER department personnel and any physician liaisons or staff Medicare reimbursement specialists may be involved.

25. If a qualified patient's hospitalization begins at the end of Year 1 and ends in Year 2, in which year should the claim be submitted for reimbursement?

For both hospitals and physicians, the claim should be submitted in the year of the hospital's discharge date.

26. If a Trauma patient's third party benefits are exhausted during the length of stay in the hospital, can the unpaid portion of the patient's case be submitted to the Fund for reimbursement?

If the third party benefits paid more than 5 percent of the total charges before they were exhausted, the claim cannot be submitted for reimbursement.

27. If a Trauma patient's third party benefits are exhausted while paying the hospital, for example, leaving no benefits to cover the physician's Trauma-related services, does the claim meet the definition of "uncompensated" on the physician side?

If the qualified physician, after diligent efforts to collect monies owed, has received payment of 5 percent or less *from any source* on the Trauma-related charges, the patient could qualify as uncompensated for the physician.

28. Can a qualified hospital or physician choose not to participate in the reimbursement process for uncompensated care?

Yes, but it is unadvisable. The purpose of the Fund is to encourage providers to use a consistent database to its full capabilities for the benefit of all Trauma victims and caregivers in the State of Mississippi. The cases that qualify as uncompensated are cases in which providers are currently receiving little or no compensation. The Fund provides a mechanism for qualified Trauma care providers to recoup some of their charges.

Additionally, the MTAC reviews the actual claims data from year to year. Issues such as allocations among Regions and providers, definitions of qualified providers and uncompensated care, and other important subjects will be determined using the actual data and input from participating providers. All qualified providers are encouraged to participate to give MTAC the most statistically significant data possible.

29. Where can I get assistance on the Trauma One software?

By contacting the Bureau of Emergency Medical Services, (601) 576-7380. The software and its installation and training are provided by BEMS at no charge to designated Trauma Centers**.**

30. Are physicians subject to audits?

Yes. Any provider that receives reimbursement from the state-administered Fund is subject to a scheduled or unscheduled audit at any time.

31. When and to which entity will the State disburse the funds?

The State will issue a check to each established Trauma Region by June 30 of the year following the claim year.

32. When can providers expect to receive disbursements?

The Regions are required to release funds to providers within 90 days of receiving them, or around September 30.

33. Our hospital is awaiting designation. We were allowed to submit a claim based on the pending designation. When may we expect to receive our funds?

Only hospitals (and those hospitals' eligible physicians) that have been completely or provisionally designated as Trauma Centers by BEMS may receive funds. If the Trauma Center is awaiting designation, the Trauma Region will hold the hospitals' and physicians' funds until the designation is achieved. If designation is not received, the funds revert back to the State for inclusion in the following year's Fund.

34. Where do providers direct questions and requests for assistance?

Horne CPA Group is under contract with BEMS and is responsible for the reimbursement process**, excluding clinical issues, fund disbursal, and audits**. Please contact:

Horne CPA Group
101 Madison Plaza
Hattiesburg, Mississippi 39402
Phone: (601) 268-1040
Fax: (601) 264-4561
www.hcpag.com

Erin Granberry
erin.granberry@hcpag.com

Christy Wilson
christy.wilson@hcpag.com

Regional directors are responsible for issuing reimbursement checks to providers. Contact information for specific Regions can be found on pages 5 – 11 of this document.

For clinical issues involving the Trauma Registry, Trauma Center inspection and designation, inclusion criteria for Registry, and for information regarding audit schedules and procedures, please contact:

Jim Wadlington
Director of Trauma System Development and Injury Control
Mississippi State Department of Health
Bureau of Emergency Medical Services
Post Office Box 1700
Jackson, Mississippi 39215-1700
Phone: (601) 576-7374
Fax: (601) 576-8140
Jim.Wadlington@ohr.doh.ms.gov
www.mstrauma.org

APPENDICES

A. Trauma Center Reimbursement Claim (sample only)

B. Qualified Surgeon Reimbursement Claim (sample only)

C. Qualified Anesthesiologist Reimbursement Claim (sample only)

D. BEMS Trauma Staff

E. Trauma Region Directors

F. Horne CPA Group Contacts

SAMPLE ONLY
2003 TRAUMA CENTER REIMBURSEMENT CLAIM
UNCOMPENSATED TRAUMA CARE

Hospital:

Address:

City, State, Zip:

Trauma Region: **Trauma Center Level:**

Submitted by: **E-mail:**

Phone **Fax:** **Date submitted:**

Beginning Date of Service	Ending Date of Service (must be in 2002)	Trauma Registry Number	DRG # or Non-IP	E-Code (from Registry)	Type of Injury (Blunt, Penetrating or Burn)	Was Trauma Team Activated? (Y or N)	Non-IP Case Result (Use only *Discharge, Expired, Transferred* or *Left AMA)*	Total Gross Charges	Total Collections as of date of submission (must be 5% or less of Gross Charges)

Make additional copies of this page as needed. Affidavit must be signed on each page. Retain a copy of each page for your records.

Trauma Center Affidavit

I certify that each case listed herein clinically qualifies for the Trauma Registry; that the hospital has complied with its collection policies; that due diligence has been exercised in the attempt to collect monies owed for these accounts for these accounts; that the cases listed herein qualify as uncompensated as defined in the policies established by the Department; and that all related account balances have been written off in full as of the date of this submission.

Trauma Center Authorized Representative Name and Title (please print or type):

Trauma Center Authorized Representative Signature:

Date:

Page ___ of ____ Total Claim Pages

SAMPLE ONLY

QUALIFIED SURGEON REIMBURSEMENT CLAIM

2003 UNCOMPENSATED TRAUMA CARE

General/Trauma Surgeons, Orthopedic Surgeons and Neurosurgeons Only

Physician Name: **Specialty:**

Practice Name:

Address:

City, State, Zip:

Trauma Region: **Hospital:**

Telephone: **Submitted by:**

Fax: **E-mail:**

Claim Year: **2002** **Date:**

				One Amount Per Code	*One Amount Per Patient*
Date of Service (Year 2002 only)	**Trauma Registry Number**	**CPT (one per line)**	**Modifier**	**Gross Charges**	**Gross Collections MUST BE 5% or LESS of Gross Charges**
Make additional copies of this page if necessary.					

Affidavit: I certify that to the best of my knowledge these submitted cases are clinically qualified for the Trauma Registry as defined by the Department. I further certify that the practice has complied with its collection policies; that due diligence has been exercised in attempting to collect monies owed for these accounts; that the cases listed above qualify as uncompensated as defined by the policies established by the Department; and that all related account balances have been written off in full as of the date of this submission.

Physician or Authorized Representative Name (please print):

Physician or Authorized Representative Signature:

Date:

Page ____ of ____ (please complete this if submitting multiple pages)

SAMPLE ONLY

2003 UNCOMPENSATED TRAUMA CARE
ANESTHESIOLOGIST REIMBURSEMENT CLAIM

Note: Anesthesiologists who are paid a fixed salary, receive a percentage of gross charges, or are compensated in other ways in which they are not financially impacted if uncompensated care is delivered are not eligible to receive reimbursement from the Fund.

Physician Name:

Practice Name:

Address:

City, State, Zip:

Trauma Region: **Hospital:**

Telephone: **Submitted by:**

Fax: **E-mail:**

Claim Year: 2002 **Date:**

Please submit all claims as if submitting to Medicare.						*One per code*	*One per patient*
Date of Service (Year 2002 only)	**Trauma Registry Number**	**ASA Code**	**CPT Code (if applicable) Surgical CPT codes without ASA codes will not be considered.**	**Modifier**	**Time Units (N/A if CPT) Do not enter actual minutes**	**Gross Charges**	**Gross Collections (must be 5% or less of Gross Charges)**

Make additional copies of this page necessary.

Affidavit: I certify that to the best of my knowledge these submitted cases are clinically qualified for the Trauma Registry as defined by the Department. I further certify that uncompensated care directly impacts my personal compensation, that the practice has complied with its collection policies; that due diligence has been exercised in attempting to collect monies owed for these accounts; that the cases listed above qualify as uncompensated as defined by the policies established by the Department; and that all related account balances have been written off in full as of the date of this submission.

Provider or Authorized Representative Name (please print):

Provider or Authorized Representative Signature:

Date:

Page ____ of ____ (please complete this if submitting multiple pages)

Mississippi State Department of Health
Office of Emergency Planning and Response
www.mstrauma.org

Jim Wadlington
Director of Trauma System Development and Injury Control
Jim.wadlington@ohr.doh.ms.gov

Trauma Program Manager
Christy Craft, BSN
christy.craft@ohr.doh.ms.gov

Post Office Box 1700
Jackson, Mississippi 39215-1700
601-576-7380
601-576-8140 (fax)

Trauma Region Directors

Central MS Trauma Region:
Brad Carter
Post Office Box 613
Jackson, Mississippi 39205-0613
Phone: (601) 206-1771
Phone: (601) 978-3445
Fax: (601) 206-1772
centraltrauma@aol.com

Coastal Trauma Care Region:
Gail Thomas
2512 Redwood Ave.
Pascagoula, Mississippi 39581
Phone: (228) 712-2866
Fax: (228) 712-9890
coastaltrauma@bellsouth.net

Delta Trauma Care Region:
Gerry Whitfield
617 Middleton Road
Winona, Mississippi 38967
Phone: (662) 283-4831
Fax: (662) 283-3877
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East Central Trauma Care Region:
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